Behavioral Health Integration: State, Local, Non-Medicaid Subgroup

Attachment 2: De-Identified Comments

#1

"Beyond wanting to protect and enhance non-MA funded services such as Res Crisis, housing and SE, do something about the worsening squeeze on grey zone PRP recipients (a squeeze that should abate somewhat if the ACA and Medicaid expansion go forward), and enhance/build in MA-reimbursement for things like respite, child crisis and peer services, I don't know how to respond to this. At the workgroup meeting, we had asked for a list of who does what at the local level and what services are delivered out of what pots of money by jurisdiction. As you say, ADAA is much different from MHA in that most of ADAA's grants (which is 86+% of their service money) goes to and is doled out by local health depts. For MHA, CSAs manage a largely non-uniform array of grant projects. We asked for a list to understand, for example, which of these services should be preserved and which not (e.g. emergency med money for consumers? the MH Court in Harford Co?). We've reached out to our members for any other thoughts, ideas and suggestions."

#2

"I think it is important to clarify the scope of the state/local role and non-Medicaid services workgroup, and differentiate between:

- Services not funded by Medicaid
- Services for non-Medicaid-eligible individuals
- Functions that should occur on the state and local level and the role of local behavioral health authorities

The merging of the state/local role workgroup and the non-Medicaid services workgroup suggests -- erroneously -- that the local role is primarly focused on non-Medicaid services. In fact, the state's core service agencies are very involved in a diverse range of activities over and above their funding of non-Medicaid services. They include many oversight and management functions relating to Medicaid-funded services. In addition, core service agencies have a history of creating new programs through innovation and serving as system-level partners with local education, social service, juvenile justice and criminal justice systems, LMBs, health departments, police, etc. If the workgroup scope includes a focus on the role of Maryland's local behavioral health authorities, then now or once the financing model is selected, Maryland should look to the experience of other states that have implemented a similar financial model, and examine those which have established effective local behavioral health authorities."

#3

A number of data requests were put forward at Tuesday's BHI State/Local/NonMedicaid Workgroup meeting. Summarized below are data elements that the Mental Health Association recommends as helpful in informing the work of this committee:

- Can we get a county by county analysis of the non Medicaid funded services that are offered in mental health and addictions (variability of offered services is significant from county to county, and it would be helpful to see a matrix which itemizes the services provided in both systems at the local level)/
- Can we get an itemization of how these services are funded in each jurisdiction (by local government, government or private sector grants, or other means) and specifically how much funding is provided by local government in each jurisdiction (mental health core service agencies have already collected some of this information in the past and may be able to quickly update or refine existing documents)?
- If we are to be examining and recommending restructuring of the local government entities that oversee behavioral health delivery, can DHMH provide:
    - An environmental scan of how local government is organized to manage these services in other states; analysis of these systems and information about effective or promising initiatives that are underway in other states
    - A summary and analysis of possible structural options for Maryland to consider that stakeholders can review and respond to

It was unclear from the discussion whether the purview of the workgroup is broad (are we examining non-Medicaid funded services needed within and outside of the Medicaid arena and how these should be organized at the state/local level) or narrow (considering the organization and interface of non Medicaid services that are needed by ***Medicaid recipients only***, without getting into a discussion of complete restructuring of state/local roles at this time)? This needs to be clarified prior to the June meeting.

Additionally since this is a time abbreviated process with just a few meetings over the summer, rather than brainstorming on the ideal system and needed services (whether for Medicaid only or all behavioral health service recipients), if the local services currently offered are shared in advance of the next meeting as requested above, along with model system of care documents for children, adults and older adults, we can have an efficient and inclusive discussion at our next workgroup meeting with a goal of clarifying those non Medicaid services needs that are most important to stakeholders. If it would be helpful for stakeholders to suggest model system of care documents prior to the next meeting, we can certainly do this and get back to you with unified recommendations from the MH Coalition on this point.

Finally, stakeholders recognize the tremendous amount of pressure this process is placing upon a very small core staff within DHMH. We view this exercise as a team effort and are ready and willing to assist in the collection of information or other functions that would be helpful in relieving some of this burden. Please do not hesitate to call upon us."